

# **ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**

## **GUIDE TO LANGUAGE IN NOTICES OF ACTION**

**OCTOBER 1, 2012**

**ATTACHMENT C, ACOM POLICY 414**

**This document is only a guide and is intended to provide examples of easily understood language. Contractors are required to use language specific to the member's situation and service request. See the AHCCCS Contract and Policies for all requirements regarding Notice of Action letter requirements. This document is not to be relied upon for legal citations. Legal citations change regularly. The Contractor is responsible for citing the correct legal source when changes to the legal basis occur.**

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## **AHCCCS GUIDE TO NOTICE OF ACTION LETTERS**

### **BACKGROUND**

When an AHCCCS Contractor makes a decision to not pay for a requested service, the Contractor must notice the member, in writing, of that decision. That written notice is called a Notice of Action (NOA) letter. This guide is intended to provide examples of language for use in NOA letters, and is not intended to be a complete reference for Federal, State, and Contractual requirements regarding NOA letters.

The point of the NOA letters is to notify members of adverse decisions and provide them with the factual basis or reason for that decision, and how to appeal that decision. NOA letters must be written such that they are easy for the member to understand. Members need to understand the reason for action so that they can decide if they want to appeal the decision, and how to best argue their case if they do decide to appeal. The better the member understands the reason for the action, the more able the member will be to participate in their health care decisions.

If additional medical information is needed to make a decision, the NOA letter must be clear enough to allow the member the opportunity to provide any additional supportive information that may assist the member in receiving the requested service. The Contractor and member do not need to rely solely on the member's physician or provider to supply any additional information. If the member has information that would help in the decision process, the member should be made aware that they can supply this to the Contractor to aid in the decision. For example, if the member has some test results or therapy notes that support their need for the requested services the Contractor must accept these as additional medical documentation.

If the member files an appeal, the issues to be decided at the hearing will be based on the specific reasons given in the NOA letter. Therefore, it is critical that the NOA letter fully and clearly explain the Contractor's justification for the action. NOA letters must include the following:

- a. the requested service;
- b. the reason/purpose of that request in layperson terms;
- c. the action taken by the Contractor (denial, limited authorization, reduction, suspension or termination) with respect to the service request;
- d. the reason for the action, including member specific facts;
- e. the legal basis for the action:  
Citations to general provisions in the AHCCCS statute or regulations or to the Contractor's internal policy manual are not sufficient. An explanation must be provided in easily understood language.
- f. where members can find copies of the legal basis; when a legal authority including an internal Contractor's policy manual is available on-line, the Contractor shall provide the accurate website link to enable the member to find the legal authority on-line.
- g. the right to appeal the decision and the process for appealing the decision; and
- h. legal resources for members for help with appeals, as prescribed by AHCCCS.

Contractors, via the NOA letter, must help members understand the decisions made by the Contractor. **A general statement that a requested service is not medically necessary, without explanation of why a service is not medically necessary, is unacceptable as a reason for the action.** Use of this or similar language as a reason for an action will result in regulatory action by AHCCCS, including but not limited to civil monetary penalties up to \$25,000 per event (letter) and/or capping of enrollment. If a Contractor determines that a service is not going to be paid for by the Contractor due to any of the main categories cited below, it is appropriate to cite the relevant regulation as the legal basis for the action. Citations must be accurate and specify the particular section of the law that is applied. However, the Contractor must also explain why a denied/ reduced service is not going to be paid for by the Contractor in language which is easily understood by the member. Refer to specific sections of the Guide for examples where the Contractor is appropriately denying or limiting services.

The NOA letter may not merely refer the member to a third party (e.g., the member's physician or case worker) in lieu of adequately citing in the letter the complete and accurate factual and legal bases for the denial / reduction or termination of a service. For example, simply telling the member to call their physician because a service is denied without providing the member specific reason for the denial is unacceptable.

Contractors must cite the AHCCCS Early Periodic Screening, Diagnosis and Treatment (EPSDT) Rule R9-22-213 and federal law 42 USC 1396(d)(r)(5) when denying, reducing or terminating a service for a Title XIX member who is younger than twenty-one (21) years of age when these provisions are applicable. When the Contractor denies, reduces, or terminates services that have been requested for Title XIX members under the age of 21, the Contractor must explain why the requested services do not meet the conditions as described in this policy and the AMPM Chapter 400, Section 430.

As explained more fully in the guide, reasons for the denial, termination or reduction of requested medical services generally fall into one of several main categories:

- I. NOT A COVERED BENEFIT OR EXHAUSTED BENEFIT;
- II. NOT MEDICALLY NECESSARY;
- III. OUT OF NETWORK PROVIDER;
- IV. NOT ENOUGH INFORMATION TO MAKE A DECISION WITHIN THE LEGALLY REQUIRED TIME FRAME;
- V. COVERAGE BY ANOTHER ENTITY;
- VI. MEMBER REIMBURSEMENT; OR
- VII. HOME AND COMMUNITY BASED SERVICES

In the event that more than one reason actually applies to a particular request by an individual or a provider, all applicable reasons should be given and explained in language that would be understood by a member.

Because AHCCCS may revise its rules to comply with program requirements, Contractors must continuously review and update the rules referenced in this Guide to ensure accuracy. It is incumbent upon Contractors to ensure that the rule references and the content in the actual NOA letters are accurate.

## **I. NOT A COVERED BENEFIT OR EXHAUSTED BENEFIT**

This should only be cited as the reason in the NOA letter when the service is not available to anyone in the AHCCCS program or to anyone in the particular demographic group to which the member belongs, such as a member over the age of 21. Additionally, in general, AHCCCS benefits are driven by medical necessity and not by an absolute limit. However, there are some services that do have a limited benefit that may be exhausted.

### **A. ACCEPTABLE Language Examples: Not a Covered Benefit or Exhausted Benefit**

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## 1. Eyeglasses for member 21 years of age and older

Your doctor has asked that we pay for eyeglasses to help you see better.

**Our decision:** We have reviewed the request and we will not pay for the (*insert service*).

### The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: AHCCCS does not pay for eyeglasses for members 21 years of age and older and if their only problem is not seeing clearly. To get eyeglasses, you must have problems seeing clearly due to surgery for cataracts. A cataract is a cloudy film on the lens of the eye. The notes from your doctor do not say you have this. Please call us at (*insert phone number*) and we will give you the names of some places that might help you get eyeglasses.

### Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	1
EPD/LTC	1 and 2

## 2. Experimental Device

Your doctor has asked us to pay for a surgery to put in a (*insert device*). This is a device that will (*purpose of device*). Your doctor has asked for this because you have (*condition*).

**Our decision:** We have reviewed the request and we will not pay for the (*insert service*).

### The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: We cannot pay for (*insert service*) because there is no medical proof that it will help you. That means it is experimental. Please call your doctor to talk about a different treatment.

### Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	3
EPD/LTC	2 and 3

### 3. Off-Label Use of Drug

Your doctor has asked us to pay for a drug called (*insert drug*). This drug is a drug commonly used for (*insert reason*). Your doctor says you need this because (*insert reason*).

**Our decision:** We have reviewed the request and we will not pay for (*insert drug*).

#### The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: This drug has not been approved by the Federal Drug Administration (FDA) to treat your problem. There are other drugs that have been approved by the FDA to help your problem. Some of these drugs are (*insert formulary drugs*). We have told your doctor about this. Please ask your doctor about which drug might help you.

#### Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	3
EPD/LTC	2 and 3

### 4. Cosmetic Surgery

Your doctor has asked us to pay for a surgery to change the shape of your nose.

**Our Decision:** We have reviewed the request and we will not pay for (*insert service*).

#### The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: The shape of your nose does not hurt your health. That means it is cosmetic surgery. We can only pay for surgery that improves your health. Please call your doctor to talk about this.

#### Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	4
EPD/LTC	2 and 4

### 5. Dental Services for Member 21 Years of Age and Older

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Your dentist has asked us to pay for cleaning of your teeth.

**Our Decision:** We have reviewed the request and we will not pay for (*insert service*).

### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: AHCCCS only pays for dental care for a medical condition for members who are 21 years of age and older. The medical condition must be acute pain, infection, or a broken jaw. The notes from your dentist do not say that your teeth are painful. The notes from your dentist do not say that your teeth are infected. Please call us at (*insert phone number*) and we will help you find low cost dental clinics.

### **Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
<b>Acute</b>	<b>5</b>
<b>EPD/LTC</b>	<b>2 and 5</b>

## **6. Fertility Clinic**

Your doctor has asked us to pay for visits to a fertility clinic. A fertility clinic is a place where women go when they have problems getting pregnant. The notes from your doctor say that you are trying to have a baby.

**Our Decision:** We have reviewed the request and we will not pay for (*insert service*).

### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: AHCCCS does not pay for care to help you get pregnant. Therefore, we cannot pay for this service. Please talk to your doctor about other ways to help you get pregnant.

### **Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
<b>Acute</b>	<b>6</b>
<b>EPD/LTC</b>	<b>2 and 6</b>

## **7. Hearing Aid for Member 21 Years of Age and Older**

Your doctor has asked us to pay for a hearing aid. A hearing aid is used to help you hear better. The notes from your doctor say you need this because (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for (*insert service*).

### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: AHCCCS does not pay for hearing aids for members who are 21 years of age or older. Please ask your doctor if there is something else that can be done for your hearing problem.

#### **Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
<b>Acute</b>	<b>7</b>
<b>EPD/LTC</b>	<b>2 and 7</b>

## **8. Personal Care Items**

Your doctor has asked us to pay for special stockings called support hose. Your doctor says you need these because (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for the (*insert service*).

### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: These special stockings can help with swelling, pain in your legs, or to prevent blood clots. The notes from your doctor do not show that you have any of these problems. The stockings would be personal care items if you do not have a medical need. Personal care items are products used to clean or care for your body. Therefore, we cannot pay for these.

#### **Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
<b>Acute</b>	<b>8</b>
<b>EPD/LTC</b>	<b>2 and 8</b>

## **9. Diapers Exceeding 240 per Month**

Your child's doctor has asked us to pay for 300 diapers a month for your child. Diapers are special underwear that

help protect the skin. The doctor's notes say your child needs these because (*insert reason*).

**Our Decision:** We will pay for 240 diapers a month. We will not pay for 300 diapers a month.

### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: We can only pay for 240 diapers a month unless your child has chronic diarrhea or spastic bladder. Chronic diarrhea is when you have loose, watery stools for a long time. Spastic bladder is a loss of bladder control. The notes from your child's doctor do not say that your child has these problems. We are approving 240 diapers a month.

*(If this request is for someone 21 years of age or older and they have no medical need for the diapers, then add the age limitations to the legal basis: Diapers are covered for members who are over 3 years old and only until the member's 21<sup>st</sup> birthday).*

### **Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
<b>Acute</b>	<b>20</b>
<b>EPD/LTC</b>	<b>2 and 20</b>

## **10. Dentures**

Your dentist has asked us to pay for dentures. Dentures are false teeth. Your dentist says you need these because (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for (*insert service*).

### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: AHCCCS does not pay for dentures. Please ask your dentist if there is something else that can be done for your problem. You may be able to get dentures through a dental school or a program that helps people get dentures at a cheaper price. You can talk with your dentist about these programs. (*The health plan may choose to attach a list of the programs that offer reduced cost dental services to adults.*)

### Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	15
EPD/LTC	2 and 15

## 11. Physical Therapy Limitation

Your doctor has asked us to pay for physical therapy (PT) 3 times a week for 12 weeks. This is a total of 36 visits. PT is a set of special exercises that will help make your muscles stronger. The notes from your doctor say you need PT because (*insert reason*).

**Our Decision:** We will pay for 15 PT visits. We cannot pay for 36 PT visits.

### The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: (*Insert member specific information.*) We can only pay for services that AHCCCS will pay for. AHCCCS will only pay for 15 PT visits each contract year. The contract year is from October 1 to September 30. We can pay for more PT next contract year if it helps your problem.

### Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	22
EPD/LTC	2 and 22

## 12. Podiatry Services

Your doctor wants you to see (*insert doctor name*). (*Insert doctor name*) is a podiatrist. A podiatrist is a special doctor who treats foot problems. The notes from your doctor say you need this because (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for (*insert service*).

### The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: Arizona state law and rules do not allow AHCCCS to pay for podiatry services. Please ask your doctor if there is something else that can be done for your (*insert reason*).

### Legal/Policy Basis Table Reference

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Plan Type	Example #
Acute	23
EPD/LTC	2 and 23

**B. UNACCEPTABLE Language Examples: Not a Covered Benefit or Exhausted Benefit:**

1. AHCCCS does not cover services or medications for cosmetic purposes.
2. AHCCCS does not cover dental services for persons 21 years of age and over except for certain conditions.
3. Treatment for infertility is not a covered benefit under the AHCCCS program.
4. Effectiveness of this treatment has not been established (experimental).
5. This treatment is a phase II clinical trial.

**II. NOT MEDICALLY NECESSARY**

Medical necessity is the most common reason for denying, limiting or terminating an authorization request. All decisions regarding medical necessity must be made by a Medical Director or other qualified medical professional. It is important that up to date information be reviewed and evaluated when taking an action relative to medical necessity. Criteria for making medical necessity decisions must be available to members and providers. Contractors must notify the members regarding what information is missing that is necessary to make a determination of medical necessity. The member must be allowed to provide needed information that may help in the determination or in the member's appeal. Lack of medical necessity may be cited in several situations, including:

1. The requested service has not been shown to be effective for the member's condition;
2. The amount, duration or scope of services requested is not necessary to treat the member's condition;
3. Other less expensive, less intrusive yet equally effective services have not been tried and failed and these are required to be tried before approving this particular service; (more conservative, less invasive or less risky procedures, plain X-rays before MRIs);

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4. Step therapy is required before approving requested drug therapy, including generic drugs or less expensive brand name drugs; or
5. The requested service is considered personal care.

## **A. ACCEPTABLE Language Examples: Medical Necessity**

### **1. Discontinuation of a Previously Authorized Service**

Your child's doctor has asked us to pay for your child's speech therapy. Speech therapy is a service that will help your child talk better. A speech therapist has been coming to your home to help your child (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for more speech therapy after (*10 days from date of letter*).

### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: The speech therapy notes say that your child (*insert member specific information*). The notes also say that your child can now talk as well as other children the same age. We can only pay for services that help your child get better. Therefore, we cannot pay for more speech therapy. Please talk to your child's doctor about this.

### **Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
<b>Acute</b>	<b>9</b>
<b>EPD/LTC</b>	<b>2 and 9</b>

## **2. Diagnostic Testing**

Your doctor has asked us to pay for Magnetic Resonance Imaging (MRI) of your (*insert body part*). An MRI is a special picture of the inside of the body. The notes from your doctor say that you need this test because (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for (*insert service*).

### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: We require that you have a regular X-ray of your (*insert body part*) before getting an MRI. We also require physical therapy to see if this will help you before an MRI is done. Physical therapy (PT) is a set of special exercises that will help make your muscles stronger. Your medical records do not show that you have had an X-ray or PT. Please talk to your doctor to see if these services are right for you.

**Legal/Policy Basis Table Reference**

Plan Type	Example #
Acute	9
EPD/LTC	2 and 9

**3. Surgery**

a.) Hysterectomy

Your doctor asked us to pay for a hysterectomy. A hysterectomy is a surgery to remove your womb. The doctor's notes say you need this because (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for the (*insert service*).

**The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: This surgery is only approved when other treatments have been tried and did not work. We can approve this surgery if the following have been met: (*insert criteria*).

Please talk to your doctor about other treatments.

**Legal/Policy Basis Table Reference**

Plan Type	Example #
Acute	9
EPD/LTC	2 and 9

b.) Gastric Bypass:

Your doctor has asked us to pay for gastric bypass surgery. This is a surgery to help you lose weight.

The notes from your doctor say you need this because (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for the gastric bypass surgery.

### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: This surgery is only paid for when other treatments have been tried and did not work. You must try other treatments first like (*insert criteria*). These treatments are less risky and may help you without the need for surgery.

### **Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
<b>Acute</b>	<b>9</b>
<b>EPD/LTC</b>	<b>2 and 9</b>

## **4. Durable Medical Equipment (DME)**

### **a.) Power Wheelchair**

Your doctor has asked us to pay for a power wheelchair. A power wheelchair is a wheeled device with a motor that lets you move around. Your doctor says you need this because (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for the (*insert service*).

### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: The notes from your doctor say you can walk around your house and safely use a regular (manual) wheelchair. We can pay for a power wheelchair if the following have been met: (*insert criteria*).

Please talk to your doctor about getting a regular wheelchair.

### **Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
------------------	------------------

<b>Acute</b>	<b>9</b>
<b>EPD/LTC</b>	<b>2 and 9</b>

#### b.) Shower Chair

Your doctor has asked us to pay for a shower chair for you to sit on while you wash yourself. The notes from your doctor say that you want this because (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for the (*insert service*).

#### The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: The notes from your doctor say you are able to stand without falling. The notes also say you do not get dizzy. We can only pay for items that help you get better. Therefore, we cannot pay for a shower chair. Please talk to your doctor about this.

#### Legal/Policy Basis Table Reference

<b>Plan Type</b>	<b>Example #</b>
<b>Acute</b>	<b>9</b>
<b>EPD/LTC</b>	<b>2 and 9</b>

#### c.) Brand Name Device

Your doctor has asked us to pay for (*insert brand name device or product*). This is a device used to (*insert information*). The notes from your doctor say you need this because (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for the (*insert brand name device or product*).

#### The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: We can pay for a (*insert generic device*). This does the same thing as a (*insert request name brand device*) and doesn't cost as much. AHCCCS can only pay for things that help you get better and are the least

costly. Please talk to your doctor about using a (*insert generic device*).

#### Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	9
EPD/LTC	2 and 9

#### 5. Genetic Testing

Your doctor has asked us to pay for genetic testing. Genetic testing uses blood tests to see what traits have been passed to a person from the parents. The doctor's notes say you need this because (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for the (*insert service*).

#### The Reasons for Our Decision:

Facts about Your Condition or Situation that Support Our Decision: The test findings will not change the treatment for your (*insert condition and explain*). We can only pay for services that will help you get better. Therefore, we can not pay for genetic testing. Please call your doctor to talk about this.

#### Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	9
EPD/LTC	2 and 9

#### 6. Custom Orthotics for Member 21 years of Age and Older

Your doctor has asked us to pay for custom orthotics. Custom orthotics are shoe inserts that are made special for you. The notes from your doctor say you need these because (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for (*insert service*).

#### The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: Arizona state law and rules do not allow

AHCCCS to pay for custom orthotics for members 21 years of age and older. You are (*insert member's age*). Therefore, we cannot pay for these. You can buy inserts for your shoes at the drug store. Please talk to your doctor to see what other care can be done to help you.

**Legal/Policy Basis Table Reference**

Plan Type	Example #
Acute	11
EPD/LTC	2 and 11

**7. Specialty Referral**

Your doctor has asked us to pay for you to see an allergist. An allergist is a special doctor who treats people with reactions to things found in their surroundings.

**Our Decision:** We have reviewed the request and we will not pay for the (*insert service*).

**The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: We cannot pay for a special doctor at this time. You need to have tried other treatments that did not work. The notes from your doctor did not tell us you have tried other treatments. We can pay for a visit to a special doctor if the following have been met: (*insert criteria*).

Please talk to your doctor about this.

**Legal/Policy Basis Table Reference**

Plan Type	Example #
Acute	9
EPD/LTC	2 and 9

**8. Pharmacy**

**a.) Step Therapy**

Your doctor has asked us to pay for (*insert drug*). This drug is commonly used for (*insert reason*). The notes from your doctor say you need this because (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for the (*insert service*).

### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: We cannot pay for (*insert drug*) until you have tried other drugs on our Drug List such as (*insert formulary drug*) and (*insert formulary drug*). These drugs are as good as the drug your doctor has asked for and cost less. We cannot pay for (*insert drug*) unless you have tried these other drugs and they have not worked for you. We have told your doctor about this. Please talk to your doctor about using one of these other drugs.

### **Legal/Policy Basis Table Reference**

Plan Type	Example #
Acute	9
EPD/LTC	2 and 9

### **b. Brand Name Medication**

Your doctor has asked us to pay for a drug called (*insert drug*). This drug is commonly used for (*insert reason*). The notes from your doctor say you need this because (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for (*insert drug*).

### **The Reasons for Our Decision:**

Facts about Your Condition or Situation that Support Our Decision: This is a brand name drug. Before we will pay for a brand name drug, you must first try a generic drug. A generic drug works the same as the brand, but costs less. The generic drug you must try first is (*insert drug*). We have told your doctor that we would pay for the generic drug but your doctor has not said this is ok. Your doctor must tell us why you cannot take the generic drug.

### **Legal/Policy Basis Table Reference**

Plan Type	Example #
Acute	9
EPD/LTC	2 and 9

## **B. UNACCEPTABLE Language Examples: Not Medically Necessary**

1. The medication prescribed for you to treat your diabetes is not on our formulary. Our records do not show your health need qualifies you to use this drug.
2. The medical information supplied does not indicate or document a sufficient need for this service.
3. We have reviewed the records from your doctor. Based on those records, the care your doctor ordered does not meet the AHCCCS standard.
4. This item is not medical in nature and therefore not needed in your medical care.
5. Medical services for incarcerated people are paid by the [ ] incarcerating facility.
6. The information submitted by your doctor does not show you meet guidelines for approval of this request.
7. The information received from your doctor does not explain the need for your treatment.
8. Dentures are not a paid benefit of (*XYZ health plan*), unless they are shown to be medically needed. The information sent by your dentist and primary care doctor does not support the medical need for dentures at this time.

## **III. Out of Network Provider**

AHCCCS Contractors may restrict members to services provided by in-network providers for the provision of non emergency services. Requests for services from out-of-network providers may be denied if the services are available and accessible in the Contractor's network.

### **A. ACCEPTABLE Language Examples:**

#### **1. Out of Network Physician**

Your doctor has asked us to pay for you to see (*insert doctor name*). The notes from your doctor say you need to see (*insert doctor name*) because (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for the (*insert service*).

### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: (*Insert doctor name*) does not have an agreement (contract) to work with us. We have other doctors who can treat your problem. These doctors have an agreement to work with us. We will help you in getting an appointment to see one of these doctors. Please call us at (*insert phone number*) for help making the appointment.

### **Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
<b>Acute</b>	<b>14</b>
<b>EPD/LTC</b>	<b>2 and 14</b>

## **2. Out of Network Facility**

Your doctor has asked that you get (*insert service*) at (*insert facility*). The notes from your doctor say you need this because (*insert problem*).

**Our Decision:** We have reviewed the request and we will not pay for (*insert service at the facility*).

### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: (*Insert facility*) does not have an agreement (contract) to work with us. There are many other places you can get the care you need. These places have an agreement to work with us. Please ask your doctor for help picking a place we will pay for.

### **Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
<b>Acute</b>	<b>14</b>
<b>EPD/LTC</b>	<b>2 and 14</b>

## **B. UNACCEPTABLE Language Examples:**

1. This doctor does not participate in our contracted network. Please talk to your doctor about finding another doctor.

2. We have reviewed your request for care at *ABC* facility. We have decided that this request will not be approved at this time. We have looked at your medical file, and decided based on medical standards that your care can be done at *EFG* facility.

#### **IV. NOT ENOUGH INFORMATION TO MAKE A DECISION WITHIN THE LEGALLY REQUIRED TIME FRAME**

In some cases Contractors do not have sufficient information to make a coverage determination within the legally required timeframes. The required timeframes are 3 working days for expedited requests, 14 calendar days for standard requests, or up to an additional 14 calendar days when an extension is given. If the Contractor needs additional information and it is in the best interest of the member, the Contractor must use the 14 day extension. The expiration of the timeframe must result in an NOA.

##### **A. ACCEPTABLE Language Examples:**

###### **Referral to Specialist**

Your doctor wants you to see (*insert doctor name*). The notes from your doctor say you need to see (*insert doctor name*) because (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for (*insert service*).

###### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: We needed more notes from your doctor to help decide if we would pay for this visit. We had to get these notes by (*insert date*). We did not get the notes. The information we needed was: (*The Contractor must insert an explanation of the information that they were seeking. The member must be given the opportunity to provide this information to the Contractor, or at the minimum, know what to ask the provider for so that the member can assist in the process.*)

Please talk to your doctor about the information we needed. Then your doctor can ask for this visit again.

###### **Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
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<b>Acute</b>	<b>9 and 12</b>
<b>EPD/LTC</b>	<b>2, 9, and 12</b>

## **B. UNACCEPTABLE Language Examples:**

1. Your doctor did not submit the requested medical information to document the need for these services. We must deny any request on day 28 in accordance with federal law.
2. We did not receive the information we needed to make the decision.

## **V. COVERAGE BY ANOTHER ENTITY**

Members or physicians may submit requests to a Contractor for services that are provided by other entities, such as the Behavioral Health System (BHS), Children's Rehabilitative Services (CRS), or Medicare.

### **A. ACCEPTABLE Language Examples:**

#### **1. Behavioral Health System**

Your doctor asked us to pay for a drug called (*insert drug*). This drug is commonly used for (*insert reason*). The notes from your doctor say you need this because (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for the (*insert drug*).

#### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: This drug has been ordered by your psychiatrist. A psychiatrist is a doctor who treats mental health problems. This drug must be paid for by (*insert RBHA*). Please contact (*insert RBHA*) at (*insert phone number*) for help getting an appointment with the mental health clinic.

#### **Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
<b>Acute</b>	<b>16</b>
<b>EPD/LTC</b>	<b>N/A</b>

## 2. Children's Rehabilitative Services (CRS)

Your child's doctor asked us to pay for (*insert service*). The notes from your child's doctor say (*insert name*) needs this because (*insert reason*). (*Explain disease/condition*)

**Our Decision:** We have reviewed the request and we will not pay for the (*insert service*).

### The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: Your child has (*insert condition*). Services to help this problem must be paid for by the Children's Rehabilitative Services (CRS). Our records say that your child is already a member of CRS. Please talk to your child's doctor about getting this service from CRS. Your child's doctor can help you with getting an appointment with CRS.

### Legal/Policy Basis Table Reference

Plan Type	Example #
Acute	17
EPD/LTC	2 and 17

## 3. Medicare Part D

Your doctor has asked us to pay for (*insert drug*). The notes from your doctor say you need (*insert drug*) because (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for (*insert drug*).

### The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: Our records show that you are covered by Medicare Part D. Federal law and Arizona state rules do not allow AHCCCS to pay for medicines that are paid for by Medicare Part D. Please talk to your doctor about this.

### Legal/Policy Basis Table Reference

Plan Type	Example #
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<b>Acute</b>	<b>24</b>
<b>EPD/LTC</b>	<b>2 and 24</b>

**B. UNACCEPTABLE Language Example:**

Your symptoms and diagnosis as documented by your primary care physician require management and monitoring by a behavioral health specialist. You must enroll with (*insert RBHA*). Please contact them at (*insert phone number*) for assistance in obtaining your medication.

**VI. MEMBER REIMBURSEMENT**

You have asked us to pay you back for (*insert item*). You bought (*insert item*) to help you (*insert reason*).

**Our Decision:** We have reviewed the request and we will not pay for (*insert item*).

**The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: We needed your doctor to order the (*insert item*) and ask us to pay for it. This is called prior authorization. You bought (*insert item*) from a local store. We will not pay you back for this. Your member handbook tells you about prior authorization and how to get services. If you do not understand this, please call us at (*insert phone number*) so we can explain this to you.

**Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
<b>Acute</b>	<b>19</b>
<b>EPD/LTC</b>	<b>2 and 19</b>

**VII. HOME AND COMMUNITY BASED SERVICES (HCBS)**

**1.Attendant Care – Initial request:**

On (*insert date of case management assessment*), you asked your case manager to have someone (an attendant caregiver) help you 24 hours every week. Attendant Care is a paid caregiver service that helps you with things you do at home every day like:

- making meals
- doing your laundry

- shopping for food and medicines
- cleaning your house
- bathing
- dressing
- going to the bathroom
- getting around your home
- moving from your bed and chair

**Our Decision:** We are going to pay an attendant care giver to help you 3 hours per day, everyday. You will get 21 hours every week. We will not pay for the other three (3) hours per week that you asked for.

### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: You told the case manager that you need help with:

- bathing,
- doing your laundry,
- cleaning your house,
- grocery shopping, and
- making your lunches and dinners.

You are able to dress yourself and get your own breakfast. The case manager notes show that the things you need help with could be done in 21 hours per week. You can get a copy of the notes (assessment) from the case management visit from your case manager.

### **Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
<b>EPD/LTC</b>	<b>2, 9, and 13</b>

## **2. Attendant Care – Reduction (Change in Situation):**

Your case manager met with you on (insert date of case management assessment), to go over your home care needs and attendant care needs. You have been getting 40 hours per week of Attendant

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Care (8 hours each day, Monday - Friday). Attendant Care is a paid caregiver service that helps you with things you do at home every day like:

- making meals
- doing your laundry
- shopping for food and medicines
- cleaning your house
- bathing
- dressing
- going to the bathroom
- getting around your home

**Our Decision:** We are reducing your attendant care from 40 hours each week to 38 hours weekly. This is 2 hours less each week. This will start on (*ten days from DATE of letter.*)

### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: Your caregiver has been spending two hours each week grocery shopping. Your daughter asked us to stop having the attendant shop for you. Your daughter said she would rather do your shopping herself. We will now begin paying for 38 hours of Attendant Care each week. You can get a copy of the notes from the case management visit from your case manager.

#### **Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
<b>EPD/LTC</b>	<b>2, 9, and 13</b>

### **3. Reduction in hours due to a change in condition (Improved Condition):**

On (*insert date of case management assessment*), you met with your case manager to go over your home care needs. You started getting more Attendant Care services (56 hours per week, 8 hours per day, 7 days per week) when you hurt your hip and leg 6 months ago. Attendant Care is a paid caregiver service that helps you with things you do at home every day like:

- making meals
- doing your laundry
- shopping for food and medicines
- cleaning your house
- bathing
- dressing

- going to the bathroom
- getting around your home  
moving from your bed and chair

**Our Decision:** We are changing your Attendant Care hours back to 28 hours each week. This is made up of 4 hours a day for 7 days a week. This is the same number of hours you were getting before you got hurt. This is 28 hours less than you were getting each week. This will start on (*at least ten days from DATE of letter*).

### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: You are done with therapy and your hip and leg are better. You are now able to bathe and dress yourself without help, so you do not need someone to do these things for you anymore. You can get a copy the notes from the case management visit from your case manager. If at any time you feel that your care needs have changed and you need more help you can speak with your case manager.

### **Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
<b>EPD/LTC</b>	<b>2, 9, and 13</b>

#### **4. Attendant Care – Substitution:**

On (*insert date of case management assessment*) you met with your case manager to go over your home care needs. You told your case manager that you would like to go to Adult Day Health 2 days each week (Wednesday and Friday) for 5 hours each time.

**Our Decision:** We will approve Adult Day Health services for you 2 days a week for 5 hours. Your Attendant Care hours however, will be reduced from 40 hours per week to 29 hours per week starting (*10 days from DATE of letter*). Your Attendant Care worker will continue to give you care for 8 hours on Tuesdays, Thursdays and Saturdays. On Wednesdays and Fridays, the worker will only help you in the morning (8am-10:30am).

### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: You have been getting 40 hours each week of

Attendant Care (8 hours per day, Tuesday – Saturday) to help with bathing, dressing, fixing your lunch and to be with you so you are safe in your home. You will be going to Adult Day Health from 11am to 4 pm on Wednesdays and Fridays starting (*insert start date, 10 days or greater from the date of letter*). You will need 2 ½ hours on those days to get ready for Adult Day Health. If at any time you feel that your care needs have changed and you need more help you can speak with your case manager about getting more care.

#### **Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
<b>EPD/LTC</b>	<b>2, 9, and 13</b>

### **5. Emergency Alert System:**

On (*insert date of case management assessment*), you met with your case manager to review your home care needs. You asked your case manager to pay for an Emergency Alert System. This is an alarm in your home that sends a signal if you need help.

**Our Decision:** We are not going to pay for an Emergency Alert System for you.

#### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: We will not pay for the alarm system for you since you have an Attendant Care worker with you for 40 hours each week and your family has told the case manager that they are with you at all other times. They have said you are rarely left alone but if you were alone that you are able to use the telephone to call for help in an emergency. There are also things you can do at home to let your family or Attendant know if you need help when they are out of the room, such as using a bell or monitor. You can speak with your case manager for some ideas to make you feel safe. You can get a copy of the notes from the case management visit from your case manager. If at any time you feel that your care needs have changed and you need more help you can speak with your case manager.

## Legal/Policy Basis Table Reference

Plan Type	Example #
EPD/LTC	2, 9, and 13

### 6. Home Modification: Other Alternatives to Home Modification:

On (*insert date of case management assessment*) you met with your case manager to review your home care needs. You asked your case manager to pay for a Home Modification. A Home Modification is when changes are made to your home that make it easier for you to do things on your own. You asked us to redo your bathroom. This includes taking away your tub and replacing it with a roll in shower. You also asked for a raised toilet (higher than normal) with handrails. You asked us to widen your door so you can wheel in with a mobile shower chair you have been given.

**Our Decision:** We are not going to pay for the removal of your tub to change it to a roll in shower. We will pay to have your shower doors removed. We will also pay to widen your door. We will not pay for a raised toilet with handrails.

### The Reasons for Our Decision

Facts about Your Condition or Situation that Support Our Decision: The notes from your case manager and the Occupational Therapist (a person trained to look at how to best change your home to meet your needs) do not tell us that these changes to your bathroom are needed. You have a bedside commode with armrests that are raised. This will fit over your toilet so you can use the toilet in your bathroom. Widening the door will let you go into the bathroom with your walker. The Occupational Therapist that visited your home will show you how to use the commode over your toilet once your bathroom door is widened. We are not going to pay to remove your tub so you can have a roll in shower. The bathroom is too small to make this possible. The Occupational Therapist that visited you said you can use your tub with a shower bench once the shower doors are taken off. The Occupational Therapist will visit you once the doors are taken off to show you and your attendant how to do this. You have a shower bench that you have not been using.

The Occupational Therapist says this will be safe and work well for you.

#### **Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
<b>EPD/LTC</b>	<b>2, 9, and 13</b>

Also, AHCCCS Medical Policy Manual, Chapter 1200, Policy 1240(J) that states AHCCCS will pay for one ramp so a member can get into and out of their home.

#### **7. Home Modification: More than one Ramp:**

On *(insert date of case management assessment)* you met with your case manager to review your home care needs. You asked your case manager to pay for a Home Modification (changes to your home that make it easier for you to do things on your own or help with your care) to put in a ramp at the back door of your home so you can go into your backyard.

**Our Decision:** We are not going to pay for a ramp at your back door.

#### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: You use a wheelchair to get around both inside and outside your home. Your home has a wheelchair ramp built at the side entrance near your driveway that you use to get into and out of your house. You told the case manager that you have no problems using this ramp. AHCCCS will pay for a ramp for a member when the member does not already have a way to safely get into or out of their home and a ramp would help them to do that.

#### **Legal/Policy Basis Table Reference**

<b>Plan Type</b>	<b>Example #</b>
<b>EPD/LTC</b>	<b>2, 9, and 13</b>

Also, AHCCCS Medical Policy Manual, Chapter 1200, Policy 1240(J) that states AHCCCS will pay for one ramp so a member can get into and out of their home.

## 8. **Cost Effectiveness Study (CES) Above 100%:**

On (*insert date of case management assessment*) you met with your case manager to go over your home care needs. You asked for 40 hours per week of Attendant Care and Home Health Nursing visits 3 times per week. Attendant Care is a paid caregiver service that helps you with things you do at home every day like:

- making meals
- doing your laundry
- shopping for food and medicines
- cleaning your house
- bathing
- dressing
- going to the bathroom
- getting around your home
- moving from your bed and chair

Home Health Nursing is a nurse who would visit you for bowel care (help emptying your bowels).

**Our Decision:** You have been approved for 40 hours per week of Attendant Care and 2 visits every week by a Home Health Nurse.

### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: You have been approved for 40 hours every week of Attendant Care. AHCCCS policy/rules do not allow Health Plans to spend more for a member's home care than we would spend for their care in a nursing home (unless the extra costs are expected to last less than 6 months). We compare the costs between a nursing home and home services as follows:

1. We start with what a nursing home would cost for you. That amount is \$4920.10 per month. Then we subtract the amount that you would have to pay **IF** you were in a nursing home. This amount is called the "Alternate Share of Cost" or "Cost Effectiveness Study (CES) Share of Cost". It is based on the income and expenses that you have reported to AHCCCS. In your case, AHCCCS has told us this amount is \$726.90 per month. If you have questions about how that amount is calculated, you can ask your case manager to talk to the AHCCCS office that did your eligibility about this.

2. The difference between the cost of your care in the nursing home and the Alternate Share of Cost is called the “Net Institutional Cost”. This is the amount we would have to pay for your care in a nursing home. Your Net Institution Cost would be \$4393.20 per month.
3. The total cost per month of the Home Health Nursing (\$1341.60) and Attendant Care services (\$2924.00) that you have asked for is \$4265.60. This total amount is called the “Net Home and Community Based Services (HCBS) Cost”. **\*\* Contractors will have to add similar language to #1 above here to cover the situations where a member has an HCBS SOC that is part of the CES calculation.**
4. If the Net HCBS Cost is more than the Net Institutional Cost, the home care services are not “cost effective” so we can not give you all of those services. Your Net HCBS cost (\$4265.60) is more than your Net Institutional Cost (\$4193.20). We can only give you services that cost \$4193.20 or less per month.

Total Nursing Home Cost	\$4920.10
CES Share of Cost	- \$726.90
<b>Net Institutional Cost</b>	<b>= \$4193.20</b>
Services you asked for	
40 hours of Attendant Care	\$2924.00
3 Nursing visits per week	+ \$1341.60
<b>Net Home Services Cost</b>	<b>= \$4265.60</b>

You told your case manager that you must have the 40 hours per week of Attendant Care. The case manager has determined that the cost of 2 Home Health Nurse visits a week along with the 40 hours per week of Attendant Care would cost \$3818.40 per month. Since this amount is less than your Net Institutional Cost, it is “cost effective” and can be authorized.

Total Nursing Home	
--------------------	--

Cost	\$4920.10
CES Share of Cost	- \$726.90
<b>Net Institutional Cost</b>	<b>= \$4193.20</b>
Services we <b>can</b> provide	
40 hours of Attendant Care	\$2924.00
2 Nursing visits per week	+ \$ 894.40
<b>Net Home Services Cost</b>	<b>= \$3818.40</b>

### Legal/Policy Basis Table Reference

Plan Type	Example #
EPD/LTC	2, 9, and 13

#### 9. **Adult Day Health for member in an Assisted Living Facility:**

On *(insert date of case management assessment)* you met with your case manager to go over your care needs. You and the Assisted Living Facility where you live asked for you attend an Adult Day Health center twice a week. Adult Day Health is a service that gives members a chance to do activities and spend time with people their own age.

**Our Decision:** We are denying your request for Adult Day Health services twice a week.

#### **The Reasons for Our Decision**

Facts about Your Condition or Situation that Support Our Decision: The type of facility that you live in is required, under their Arizona Department of Health Services license, to offer daily activities that are planned for the people that live there. Your case manager will talk to the Assisted Living Facility manager about the activities your facility has and will ask them to talk with you about what kinds of activities you would be interested in.

**Legal Basis for Our Decision:** We based our decision on Arizona Administrative Code (AAC) Section R9-10-

712 that says Assisted Living Facilities have to have activities for the people who live there.

## **REFERENCES**

42 CFR 438 et seq

A.A.C. R9-22 et seq

A.A.C. R9-28 et seq

Ekloff v Rodgers Settlement Agreement AAC R9-22-212

AHCCCS Medical Policy Manual

Web address for all Arizona Administrative Codes:  
<http://www.azahcccs.gov/reporting/LawsRegulations/state/state.aspx>

AHCCCS Medical Policy Manual web link:  
<http://www.azahcccs.gov/shared/MedicalPolicyManual/MedicalPolicyManual.aspx?ID=contractormanuals>

Number	Description	Legal Basis or Policy	TABLE: Legal Basis or Policy in Easily Understood Language
1	Not Covered: Eyeglasses for member 21 and older	R9-22-212 (E)(8)(b)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-212 (E)(8)(b) that says AHCCCS only pays for eyeglasses for members until a member has their 21 <sup>st</sup> birthday, unless they have had eye surgery for cataracts.
2	EPD / LTC covers same services as Acute	R9-28-202	We based our decision on Arizona Administrative Code (A.A.C.) R9-28-202 that says the Long Term Care Program pays the same services as the Acute Program.
3	Not Covered: Experimental/ Clinical Research	R9-22-202(B)(9)(a) & R9-22-203	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-202(B)(9)(a) that says AHCCCS does not pay for experimental services. The definition of experimental services can be found at Arizona Administrative Code (A.A.C.) R9-22-203. If you would like help understanding the definition please call us at <i>(insert phone number.)</i>
4	Not Covered: Cosmetic Services	R9-22-215(C)(4)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-215(C)(4) that says AHCCCS does not pay for cosmetic procedures.
5	Not Covered: Dental Services for members 21 and older	R9-22-207(B) & AMPM Chapter 300 - dental coverage	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-207(B) that says AHCCCS only pays for dental services for members 21 years of age and older related to a medical condition such as acute pain, infection, or fracture of the jaw. Temporomandibular Joint Dysfunction (TMJ) services are not covered except for reduction of trauma.
6	Not Covered: Infertility Treatment	R9-22-205(B)(4)(a)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-205(B)(4)(a) that says AHCCCS does not pay for infertility services.
7	Not Covered: Hearing Aids for member 21 and older	R9-22-212(E)(8)(a) and AMPM Chapter 300, Policy 310	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-212(E)(8)(a) that says hearing aids are not paid for members who are 21 years of age or older. There is a list of paid for services for hearing aids in the AHCCCS Medical Policy Manual Chapter 300, Policy 310.
8	Not Covered: Personal Care Items	R9-22-212(E)(5) & R9-22-	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-212(E)(5) and Arizona Administrative Code (A.A.C.) R9-22-202(B)(9)(c) that says AHCCCS does not pay for personal care items.

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Number	Description	Legal Basis or Policy	TABLE: Legal Basis or Policy in Easily Understood Language
		202(B)(9)(c)	
9	Medically Necessary and Cost Effective	R9-22-202(B)(1)	We based this decision Arizona Administrative Code (A.A.C.) R9-22-202(B)(1) that says AHCCCS only pays for services that are medically necessary, or will help you get better. Also, services must be the least costly service that will give you the same result (cost effective).
10	EPSDT Guideline	R9-22-213 & 42 USC 1396 (d)(r)(5)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-213 and federal law 42 USC 1396(d)(r)(5) that says AHCCCS pays for services listed in federal law 42 USC 1396(d)(a ) that help or make better an injury, illness, condition or defect whether or not the service is in the AHCCCS State Plan.
11	Orthotics for Members Age 21 and Older	A.R.S 36 – 2907(B)& R9-22-212 (E)(8)(h)	We based our decision on Arizona Revised Statute (A.R.S.) §36-2907(B) and Arizona Administrative Code (A.A.C.) R9-22-212 (E)(8)(h) that says AHCCCS does not pay for orthotics for members age 21 and older.
12	Decision not made within timeframes and therefore considered denied	R9-34-206(E)	We based our decision on Arizona Administrative Code (A.A.C.) R9-34-206(E) that says that when authorization decisions are not reached within the timeframe allowed by rules, the health plan must deny the request.
13	Definition of medically necessary	R9-22-101(B)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-101(B) that says that to be medically necessary a service must prevent disease or disability; help avoid bad problems that may occur due to your disease process; stop your disease or condition from getting worse; or will help you live longer or keep you in your home.
14	Out of Network	R9-22-705(A)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-705(A) that says that AHCCCS health plans may only pay for services to providers they are contracted with unless the health plan referred you to the provider or the service is an emergency.

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Number	Description	Legal Basis or Policy	TABLE: Legal Basis or Policy in Easily Understood Language
15	Dentures- not a covered benefit	R9-22-207(B)(2)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-207(B)(2) that says AHCCCS does not pay for dentures for members age 21 years and older.
16	Acute Care Only - services covered by the Division of Behavioral Health	R9-22-1202(A) & R9-22-1202(C)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-1202(A) & Arizona Administrative Code (A.A.C.) R9-22-1202(C) that require the behavioral health system to provide your behavioral health drugs and the medical care related to those drugs.
17	Services covered under the Children's Rehabilitative Services benefit	R9 -7-301(B)	We based our decision on the Arizona Administrative Code (A.A.C.) R9 -7-301(B) that says primary care providers and other practitioners shall refer a child with special health care needs to Children's Rehabilitative Services (CRS).
18	AHCCCS is the payor of last resort	R9-22-1003	We based our decision on the Arizona Administrative Code (A.A.C.) R9-22-1003 that says that AHCCCS must not pay for services if other insurance companies will pay for them.
19	AHCCCS is not obligated to pay for services that require prior authorization, when prior authorization is not obtained	R9-22-202(C)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-202(C) that says a health plan does not have to pay for services or equipment that require prior authorization when prior authorization is not obtained.
20	Incontinence Briefs/Diapers	R9-22-212(E)(5) & R9-22-212(E)(6)	We based our on decision on Arizona Administrative Code (A.A.C.) R9-22-212(E)(5) and Arizona Administrative Code (A.A.C.) R9-22-212.E(6) that says:  (E)(5) Except for incontinence briefs for persons over 3 years old and under 21 years old as provided in subsection (E)(6), personal care items including items for personal cleanliness, body

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			<p>hygiene, and grooming are not covered unless needed to treat a medical condition. Personal care items are not covered services if used solely for preventive purposes.</p> <p>(E) (6) Incontinence briefs, including pull-ups are covered to prevent skin breakdown and enable participation in social, community, therapeutic and educational activities under the following circumstances:</p> <ul style="list-style-type: none"> <li>a. The member is over 3 years old and under 21 years old;</li> <li>b. The member is incontinent due to a documented disability that causes incontinence of bowel or bladder, or both;</li> <li>c. The PCP or attending physician has issued a prescription ordering the incontinence briefs;</li> <li>d. Incontinence briefs do not exceed 240 briefs per month unless the prescribing physician presents evidence of medical necessity for more than 240 briefs per month for a member diagnosed with chronic diarrhea or spastic bladder;</li> <li>e. The member obtains incontinence briefs from providers in the contractor's network;</li> <li>f. Prior authorization has been obtained as required by the Administration, contractor, or contractor's designee. Contractors may require a new prior authorization to be issued no more frequently than every 12 months. Prior authorization for a renewal of an existing prescription may be provided by the physician through telephone contact with the member rather than an in-person physician visit. Prior authorization will be permitted to ascertain that: <ul style="list-style-type: none"> <li>i. The member is over age 3 and under age 21;</li> <li>ii. The member has a disability that causes incontinence of bladder or bowel, or both;</li> <li>iii. A physician has prescribed incontinence briefs as medically necessary. A physician prescription supporting medical necessity may be required for specialty briefs or for briefs different from the standard briefs supplied by the contractor; and</li> </ul> </li> </ul> <p>iv. The prescription is for 240 briefs or fewer per month, unless evidence of medical necessity for over 240 briefs is provided.</p>

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21	Pancreatic Islet Cell Transplants (applicable to partial and whole pancreas transplants)	R9 - 22-206(B)(3)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-206(B)(3) that says AHCCCS does not pay for partial pancreas or whole pancreas transplants using islet cells from the member.
22	Physical Therapy Limitation	R9-22-215(C)(6)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-215(C)(6) that says AHCCCS will only pay for 15 physical therapy visits each contract year. The contract year is from October 1 to September 30.
23	Podiatry Exclusion	R9-22-215(C)(5)	We based our decision on Arizona Administrative Code (A.A.C.) R9-22-215(C)(5) that says services provided by a podiatrist are not covered.
24	Medicare Part D	42 USC § 1396u-5(d) and R9-29-302	We based our decision on the Federal code 42 USC § 1396u-5(d) and Arizona Administrative Code (A.A.C.) R9-29-302 that say AHCCCS cannot pay for medications covered by Medicare Part D.

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